

DEPARTMENT OF BENEFIT PAYMENTS
744 P Street, Sacramento, CA 95814

December 11, 1974

ALL-COUNTY LETTER NO. 74-251

TO: ALL COUNTY WELFARE DIRECTORS

Superseded by

*All Co. Letter 76-27*Issued *2-13-76*

SUBJECT: FOOD STAMP PROGRAM - REVISED FORM WR 2A, STATEMENT OF FACTS TO SUPPORT
FOOD STAMP CERTIFICATION SUPPLEMENT
REFERENCE:

Attached for your review and contingency planning is the revised (12/74) WR 2A, supplemental statement of facts to support food stamp certification for public assistance households, and form instructions.

Bulk supplies of this form will not be received by counties for another 60 to 90 days. Because of a backlog in printing and because the revision reflects only minor changes to the 2/74 version, the 2/74 version may be used until sufficient supplies of the 12/74 revision are received. Supplies of the 2/74 WR 2A are in stock and may be ordered from the state through the usual channels.

Other options available to counties are:

- 1) Printing your own interim supplies of the attached WR 2A, or
- 2) Use of the current DFA 285 in lieu of the WR 2A.

If your county chooses to use supplies of the 2/74 WR 2A, the following pen and ink changes must be made:

Page 2, Section IV

Items 2, 3, and 4. Delete the word "owe" where appearing in each sentence.

Item 2. Delete the word "uninsured" in first line of the sentence.

Item 3. Add to sentence: "or for any person for whom the household would normally have financial responsibility."

Page 2, Section V

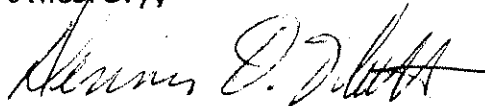
Item 1. Reword "homeowners insurance" to read: "homeowners insurance on the structure itself, but not separate costs for insuring furniture or personal belongings."

Page 3, Authentication

Substitute the words "within ten days" for "at once" on first line of first paragraph. Line out words "real property holdings", and "personal possessions" where appearing in same paragraph.

Please direct any questions to Charles Teal, Program Operations, Food Stamp Management Branch at (916) 445-6907.

Sincerely,



DENNIS O. FLATT
Deputy Director

cc: FNS-USDA
CWDA

Attachment

SUPPLEMENTAL STATEMENT OF FACTS TO SUPPORT FOOD STAMP CERTIFICATION FOR PUBLIC ASSISTANCE HOUSEHOLDS

(Complete all items. If the only answer is "None" write "None" in the blank provided.
If the item does not apply to you, write "Not Applicable" or "N/A.")

NAME OF HEAD OF HOUSEHOLD (LAST, FIRST, MIDDLE)		MAIDEN NAME	COUNTY USE ONLY COUNTY
			CASE NUMBER
			PUBLIC ASSISTANCE CASE NUMBER(S)

MAILING ADDRESS (NUMBER, STREET, ROUTE NUMBER-CITY, COUNTY, STATE, ZIP CODE)	TELEPHONE NUMBER OR NUMBER WHERE MESSAGES MAY BE LEFT	COUNTY USE ONLY
ADDRESS WHERE RESIDING (IF DIFFERENT FROM ABOVE) (NUMBER, STREET, ROUTE NUMBER-CITY, COUNTY, STATE, ZIP CODE)		

DIRECTIONS TO HOME (WORKER COMPLETION ONLY)

II. THE FOLLOWING PERSONS LIVE IN THE HOUSEHOLD

Give the following information for all persons living in your household, except SSI recipients, roomers, boarders, or persons who provide nursing care, housekeeping service, or child care. List these exceptions in NO. III.

NAME (Last, First, Middle Initial)	AGE	RELATIONSHIP TO HEAD OF HOUSEHOLD (Son, wife, step-child, etc.) If unrelated enter "NONE"	Employment Status (see below)	Each member marked "H" is registered for work	
				YES	NO
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

EMPLOYMENT STATUS CODES

- A. Mother or other household member with responsibility for care of sick or disabled or dependent children under 18.
- B. Students enrolled at least half time in a school or training program.
- C. Persons working at least 30 hours per week.
- D. Persons unable to work for mental or physical health reasons.
- E. Persons self employed on a full-time basis.
- F. Under 18 years of age.
- G. Over 65 years of age.
- H. Available for employment (such persons unless already registered for work through AFDC, must complete a Work Registration form before eligibility for food stamps can be established.)

III. Do any of the persons living in the home pay for board, room or both? ☐ Yes ☐ No

1. If Yes, give this information:

NAME (Last, First, Middle)	CHECK (✓)			AMOUNT PAID	HOW OFTEN		
	Room	Board	Both		Weekly	Monthly	Other

V. Do you expect any change in your household circumstances — income, resources, living arrangements, expenses or other circumstances — in the near future? ☐ Yes ☐ No If Yes, explain in detail.

COUNTY USE
ONLY

VI. If eligible for Food Stamps, I would like to purchase (check one):

☐ TWICE A MONTH ☐ ONCE A MONTH

VII. I/We would like the cost of Food Stamps withheld from my/our grant (if county provides this service).

☐ YES ☐ NO

VIII. CERTIFICATION

I certify that this application has been examined by me (or read to me) and that the information given is true and correct to the best of my knowledge and belief. I agree to provide the County Food Stamp Office information necessary to verify any statements given in this application and hereby give permission to obtain such verification. I will also cooperate fully with state and federal personnel in a quality control review.

I agree to inform the County Food Stamp Office within 10 days of changes in income and/or deductions whenever such changes reach a total of more than \$25.00 per month within the period of eligibility or of any change in household composition or living arrangement, and of any change in any other information I have given since such changes may affect eligibility to purchase food coupons or the amount to be paid for them.

I understand that when I plan to move to another county or state it may be possible for me to transfer my food stamp eligibility with me PROVIDED that I report the move to this food stamp office prior to my departure and obtain a transfer document FNS-286.

NONDISCRIMINATION: This application will be considered without regard to race, color, religious creed, national origin, or political beliefs.

I understand that I have a right to a hearing if I am not satisfied with the action taken on my application by the food stamp office. I may discuss the action with the County Welfare Department. If I am not satisfied with this discussion, I may request a hearing by the Department of Benefit Payments. The request may be written or oral, and must state why I am not satisfied. The request must be received by the Office of the Chief Referee, DBP, 744 P Street, Sacramento, California 95814, within 90 days of the postmarked date of the Notice of Adverse Action with which I am dissatisfied. I may be entitled to have my food stamps continued if I request a fair hearing within 10 days of the postmarked date of the Notice of Adverse Action.

BEFORE YOU SIGN YOUR NAME GO BACK AND CHECK TO SEE THAT EACH ITEM THAT APPLIES TO YOUR HOUSEHOLD HAS BEEN ANSWERED ACCURATELY.

PENALTIES FOR FRAUD: The state and federal law provides penalties including a fine, imprisonment or both for persons found guilty of obtaining food stamps for which they are not eligible by making false statements; or

FAILURE TO REPORT PROMPTLY any changes in their circumstances. If evidence indicates that such individuals have willfully violated the law, they will be referred to the proper law enforcement authority for investigation and possible prosecution.

ANYONE WHO AIDS another person to obtain food stamps fraudulently is subject to the same penalties.

SIGNATURE OF HEAD OF HOUSEHOLD

DATE

SIGNATURE (AUTHORIZED REPRESENTATIVE OR OTHER PERSON COMPLETING APPLICATION)

DATE

If an Authorized Representative completes application attach written authorization of head of household or spouse.

IF SIGNED BY "X" SIGNATURE OF WITNESS

DATE

SIGNATURE OF ELIGIBILITY WORKER COMPLETING CERTIFICATION

DATE

If I would like to have someone else purchase your coupons for you, give his name and address.

2. Does any member live in the home to provide nursing care, housekeeping services or care for child so that you or other members of the household can work? ☐ Yes ☐ No
If Yes, give this person's name: _____

3. Do any other persons live in the home? If so, give names and status — for example, do they share the home or rent? Do they live as a separate household unit? Explain fully: _____

4. Do you have a place to prepare cooked meals where you live? ☐ Yes ☐ No

5. Are you or your spouse unable to prepare meals because of health problems? ☐ Yes ☐ No If Yes, do you receive meals from either:
A. Meals on wheels program? ☐ Yes ☐ No
B. A communal dining facility? ☐ Yes ☐ No

6. Are you, or any member of the household, a member of a drug addict or alcoholic rehabilitation treatment center? ☐ Yes ☐ No If Yes, give name _____

Do you participate on a ☐ resident or ☐ nonresident basis?

COUNTY USE ONLY

☐ 3. Necessary Person Case

IV. EXPENSES.

Give the following information about your household expenses.

LIST ONLY THOSE EXPENSES ACTUALLY BEING PAID.

Expenses paid by another person or source are to be included.

HOW OFTEN ARE EXPENSES ACTUALLY PAID

	AMOUNT	Weekly	Every 2 Weeks	Twice Monthly	Monthly	NUMBER OF MONTHS TO BE PAID
1. SHELTER						
a. Rent or mortgage payment on home.	\$					
b. Utilities (if not included in rent)						
(1) Heating and cooking fuel	\$					
(2) Electricity	\$					
(3) Telephone (basic charge for one)	\$					
(4) Water	\$					
(5) Sewage disposal fees.	\$					
c. Taxes and assessments — (Yearly payments)						
(1) Real estate taxes on home	\$					
(2) Special assessments (if required by law)	\$					
2. MEDICAL						
a. Physician and dental services	\$					
b. Hospital or nursing care	\$					
c. Health insurance and medicare	\$					
d. Prescription drugs.	\$					
e. Transportation costs for medical care	\$					
f. Other (specify) _____	\$					
3. UNUSUAL						
a. Replacement or repair of property damaged or lost through vandalism, fire, theft, flood, storm, etc. (Explain on separate page, sign and date.)	\$					
b. Funeral expenses paid by a member of the household (Explain on separate page, sign and date.)	\$					
4. OTHER						
a. Payments for the care of a child or another person when necessary for a household member to work outside the home.	\$					
b. Tuition and mandatory fees for education (do not include cost of books or materials)	\$					
(1) When paid? _____						
(2) For whom paid? _____						
(3) To whom paid? _____						
(4) Period covered by payments: From _____ To _____						
Court-ordered support/alimony payments						

5. Does someone who is not a member of the household pay for any of these or other expenses? ☐ Yes ☐ No

If Yes, give the following information:

NAME OF PERSON (Last, First, Middle)	TYPE OF EXPENSE	AMOUNT PAID
		\$
		\$
		\$

INSTRUCTIONS ON FORMS (Continued)

WR 2A Supplemental Statement of Facts to Support Food Stamp Certification

The WR 2A form may be used to support food stamp certification for any Assistance Household (as defined in Section 63-2110) who applies for food stamps and already has on file a current WR 2 form that was completed in establishing the household member's eligibility for public assistance. When used, the form is to be completed, signed and dated by the head of the household, his or her spouse, or the household's authorized representative.